MDR Tracking Number: M5-05-0403-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-28-04.

The IRO reviewed range of motion measurements, chiropractic manipulative treatment extra spinal one or more regions, office visits, chiropractic manipulative treatment 3-4 regions, application of modality diathermy, unlisted therapeutic procedure, therapeutic procedure massage, application of a modality traction mechanical rendered from 11-06-03 through 05-07-04 that were denied based upon "V" and "U".

The IRO determined that services from 11-06-03 through 11-26-03 **were** medically necessary. The IRO further determined that services from 01-22-04 through 05-07-04 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-04-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99070 date of service 10-16-03 (refreezable Cryo Packs DME #33-$18.33, sitback rest DME #22-$28.50, biofreeze DME #28-$8.00), 10-20-03, 12-15-03, 01-19-04 (consumable TENS supplies DME #5 or DME#6-$25.00 X 3) and 02-18-04 (biofreeze DME #28-$8.00) denied with denial code "G/B377" (bundled procedure no separate payment allowed). The carrier per Rule 133.304(c) did not specify which service charges were global to. Reimbursement is recommended per the Medical Fee Schedule effective 08-01-03 in the amount of $137.83.

CPT code 97024 date of service 11-05-03 denied with denial code "F/M456 (the maximum number of physical therapy services has been exceeded for this date of service). Per the Medicare Part B LCD for Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries Contractor Policy Number Y-13.5 the number of modalities has not been exceeded. The MAR per the Medicare Fee Schedule is $5.54 ($4.43 X 125%). The requestor billed $5.53 therefore this is the recommended reimbursement.

Review of CPT codes 97110, 98940, 97150, 97124, 99070 date of service 12-12-03, 99212-25 date of service 12-15-03 and 97139-EU date of service 01-07-04 revealed that neither the requestor nor respondent submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of carrier receipt of the providers request for EOBs. Per Rule 133.307(e)(3)(B) the respondent did not provide EOBs as required. Therefore services are not reviewed and no reimbursement is recommended.

CPT code 97012 date of service 12-15-03 and 12-17-03 denied with denial code "F/M456 (the maximum number of physical therapy services has been exceeded for this date of service). Per the Medicare Part B LCD for Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries

Contractor Policy Number Y-13.5 the number of modalities has not been exceeded. The MAR per the Medicare Fee Schedule is $17.21 ($13.77 X 125%). The requestor billed $17.20 therefore the recommended reimbursement is $34.40 ($17.20 X 2 DOS).

CPT code 99080-73 date of service 02-06-04 denied with denial code "V" (unnecessary medical treatment based on a peer review). Per the respondent's EOB of 12-02-04 payment has been made in full via check number 09535599. Therefore no dispute exists.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 10-16-03, 10-20-03, 11-05-03, 11-06-03, 11-24-03, 11-26-03, 12-15-03, 12-17-03 and 01-19-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 5th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Date: November 30, 2004

To the Attention Of:
Rosalinda Lopez
TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-0403-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents

utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- 11/11/04 report, which is a summary of the provider's position regarding the IRO
- Initial medical narrative report dated 10/16/03 from the treating chiropractor, Dr. W
- Subsequent medical narrative report dated 11/6/03 from Dr. W
- Lumbar range of motion assessment report of 11/6/03
- Left hip range of motion assessment report of 11/6/03
- 2/6/04 note from Dr. W stating the claimant was to be taken back off work because the employer was not adhering to the prescribed work restrictions
- 5/6/04 request for a detailed job title and description from the employer from Dr. W
- Multiple daily chiropractic treatment notes from 10/16/03 through 4/15/04
- Multiple reports from the ___ dated 10/29/03, 1/30/04 and 3/11/04
- Orthopedic consultation report from Dr. B, M.D., orthopedist, dated 12/1/03
- Neurological evaluation and electrodiagnostic testing report from Dr. L dated 11/20/03
- MRI of the lumbar spine, pelvis and left hip dated 11/4/03 and 10/30/03
- Designated doctor report dated 9/28/04 from Dr. O, M.D. revealing the claimant to be at MMI as of that date with 5% whole body impairment rating
- Request for clarification of the designated doctor report from Dr. W dated 10/6/04. He was disagreeing with the claimant's MMI date and impairment rating because the claimant was reportedly still involved in a chronic pain management program
- 5/24/04 behavioral evaluation from ___, LPC
- TWCC-69 report and narrative report from Dr. R, M.D. who served as a carrier selected RME doctor dated 6/25/04 revealing the claimant was likely at MMI with no impairment
- Professional Reviews chiropractic modality review report of 3/24/04 revealing that 24 sessions of treatment from 10/16/03 through 2/2/04 would be recommended given the diagnoses and other recommendations
- Multiple physical therapy notes from approximately 10/21/03 through 1/20/04
- Voluminous amounts of TWCC-73 reports mostly from Dr. W dated 10/16/03, 11/5/03, 11/12/03, 1/12/04, 1/27/04, 2/6/04, 2/18/04, 2/24/04, 3/16/04, 4/15/04. 5/6/04, 6/29/04, and 9/28/04

Submitted by Respondent:

- None provided

Clinical History

The documentation provided for review revealed that the MRI evaluations of the pelvis, left hip and lumbar spine were stated to be normal. The claimant's electrodiagnostic work ups were normal. Dr. B, M.D., orthopedist, felt the claimant had a left sacroiliac joint problem only. Dr. L, neurologist, felt the claimant only had myofascial findings.

According to the documentation submitted for review, the claimant suffered a slip and fall injury on some chicken fat at a poultry processing plant on ___. The documentation revealed the claimant suffered other slip and fall injuries in ___ as well as on ___. The documentation also suggested that a dolly had fallen on the claimant's neck and back in ___. There was some discrepancy because some of the documentation revealed the claimant had slipped and fallen at that time period. At any rate, the claimant had sustained at least 3 workers' compensation accidents with the same employer within a 3 year period. The documentation was carefully reviewed and was very indicative of sprain/strain injury only.

The claimant's nerve root tension signs of evidence of left sided lumbar radiculopathy subjectively could not be verified objectively. There was very little evidence of damage or added physical damage that occurred to the claimant's physical structure as a result of the ___ injury. In fact, on 11/20/03 Dr. L documented the presence of "no paravertebral muscle spasm". Dr. B and Dr. L felt the claimant had no evidence of lumbar radiculopathy and Dr. R documented the presence of a few Waddell's signs to include glove and stocking distribution of pain and numbness in the left leg as well as oversensitivity to light touch. There was a striking lack of physical evidence of significant injury. The documentation does suggest that left sided sacroiliac joint and lumbar sprain/strain injury probably occurred.

Requested Service(s)

95851 – range of motion measurements, 98943 – chiropractic manipulative treatment extra spinal one or more regions, 99213 - office visit, 98941 – chiropractic manipulative treatment 3-4 regions, 97024 – application of a modality diathermy, 97139 – unlisted therapeutic procedure, 97124 – therapeutic procedure massage, 99212 – office visit, 99211 – office visit, 97012 – application of a modality traction mechanical for dates of service 11/6/03 through 5/7/04.

Decision

I disagree with the carrier and find that the services rendered from 11/6/03 through 11/26/03 were medically necessary. I agree with the carrier and find that the services rendered from 1/22/04 through 5/7/04 were not medically necessary.

Rationale/Basis for Decision

The services rendered from 11/6/03 through 11/26/03 as part of this dispute were mainly regarding hip and lumbar range of motion studies as well as chiropractic manipulative treatment to the claimant's left hip. It is my opinion that these services were reasonable and medically necessary because the treatment did encompass the appropriate treatment areas and were well within well recognized evidence based treatment guidelines recommendations. The highly evidence based Official Disability Guidelines recommend about 18 visits of chiropractic treatment over a 6-8 week period for various sprain/strain injuries. It would also be appropriate for the claimant's hip and lumbar range of motion to be measured and this was done appropriately and within the normal treatment time and natural history of the diagnosed conditions. It has been documented that the claimant essentially has a left sacroiliac joint and lumbar sprain/strain injury with some left hip involvement. There was absolutely no evidence of lumbar radiculopathy and the claimant's MRI evaluations of the lumbar spine, hip and pelvis were normal.

The services and treatments which occurred from 1/22/04 onward would not be considered medically necessary because this would be beyond the natural history of the sprain/strain injury. It was quite clear in the documentation that very limited clinical sequelae had occurred and this condition should have resolved within a 6-8 week period. Because there are mixed issues involved in this dispute, there was a large gap in the disputed dates of service from 11/26/03 through 1/22/04. Therefore, I have stated that the medical necessity of the services beginning on 1/22/04 onward would not be considered medically necessary.

In summary, I was only asked to review services on 11/6/03, 11/24/03, 11/26/03, 1/22/04, 2/6/04, 2/10/04, 2/13/04, 2/16/04, 5/6/04, and 5/7/04. Again, it is my recommendation based on the provided medical records and documentation as well as the diagnoses that the services rendered that are in dispute from 11/6/03 through 11/26/03 was medically necessary. The remaining services would not be considered medically necessary for the rationale and reasons already mentioned above.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this ___30__ day of _____November_____ 2004.

Signature of IRO Employee: